ABSTRACT

SOCIAL WORK

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AN EXPLORATORY DESCRIPTIVE STUDY OF HEALTH SEEKING BEHAVIORS, ECONOMIC FACTORS, AND BREAST CANCER TREATMENT DECISION MAKING AMONG AFRICAN AMERICAN WOMEN

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Thesis dated May, 1999

This exploratory descriptive study assessed the relationship between health seeking behavior, economic factors, and breast cancer treatment decision making among African American women.

A self-administered twenty item questionnaire was used to collect data from African American women. There were 30 African American women who agreed to participate in the survey. Descriptive, frequency, percentages, and Chi Square statistics were used to analyze the data.

The findings revealed that there were no statistically significant relationships between health seeking behaviors, economic factors, and breast cancer treatment decision making among African American women. The hypothesis was rejected.

AN EXPLORATORY DESCRIPTIVE STUDY OF HEALTH SEEKING BEHAVIORS, ECONOMIC FACTORS, AND BREAST CANCER TREATMENT DECISION MAKING AMONG AFRICAN AMERICAN WOMEN

A THESIS

SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR

THE DEGREE OF MASTER OF SOCIAL WORK

BY

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SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA

MAY 1999

R. = vi P. 61

ACKNOWLEDGEMENTS

I would like to acknowledge the following persons: First, I would like to thank the Almighty God for helping me reach this point in my career because with Him all things are possible and without Him, I can do nothing; Professor Hattie Mitchell for helping me complete this thesis and her words of encouragement when times got rough; and to my parents, Mr. And Mrs. Charlie Jenkins, for their love and support. Finally, I would like to thank Meisha Nimmons, Nimmons Business Services, for all her hard work in assisting in the completion of the typing of this thesis.

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CHAPTER ONE

INTRODUCTION

This study seeks to examine relationships between Health Seeking Behaviors, Economic Factors, and Breast Cancer Treatment Decision Making among African American Women.

This is a relevant empirical research area for social work practitioners to understand and appreciate. Hopefully, this study will address a major gap in social work literature on the health seeking behaviors, economic factors, and breast cancer treatment decision making among African American women.

Jablon and Volk (1960), expressed the fact that the social and psychological concomitants of cancer are profound and extensive, and treatment health care professionals inevitably need to grapple with these allied issues. The social worker client relationships must encompass concern and activity to help a client with the anxieties evoked by the illness and the treatment process. It is tacitly assumed thereby that a social work practitioner would have the skillfulness generally to help clients in the broader sense. Toward this goal, this empirical social work research study offers some deeper understanding of a critical problem facing African American women in managing breast cancer treatment.

Edmonds (1993), noted that it is difficult to collect reliable data on health-related matters in the Black community because the reactions to health problems and the

reporting of health problems appears to be different from those exhibited by other races. Black patients' health seeking behavior is conditioned by customs, culture, and psychosocial factors, and the majority of illnesses experienced by the Black patients are chronic in nature.

In determining the appropriate type of social work treatment for the African American breast cancer client, the stage of the disease is clearly the critical differentiating factor. The nature of a social work practitioner's service to African American women with breast cancer is bounded and determined by an African American woman's awareness of her situation. Social work service will need to be geared closely to the client's understanding of the medical condition.

Social work practitioners will be better able to evaluate the social and psychological facets of the African American woman's health seeking behaviors, economic factors, and breast cancer treatment regimen when they have some clear and specific criteria by which to guide them. Of course, this study has wider pertinence in relation to all breast cancer patients.

Ries, Hankey, & Edwards, (1990) noted in the article "Cancer and Black Americans" found that Blacks have significantly higher aged-adjusted cancer incidence rates than Whites. The specific cancers for which Blacks have higher incidence than Whites include oral cavity, esophagus, lung (males), breast (females under age forty) cervix uteri, prostate, stomach, and pancreas. Trends in age-adjusted cancer incidence

from 1976 to 1987 indicate that Blacks experience higher increases in incidence than Whites for most sites and lower decreases in incidence for sites where decreases occurred (National Cancer Institute, 1989). The one exception to this trend is cancer of the cervix, for which Black women experienced a greater decrease in incidence than White women, although the incidence rate remained more than twice as high in Blacks as in Whites.

The disparity between Blacks and Whites is most striking for cancer mortality. Blacks have mortality rates 20 to 40 percent higher than the general population (National Cancer Institute, 1989). The mortality rates for Whites are decreasing, for example, colon, rectum, pancreas, and stomach. The rates for Blacks are either increasing (colon- rectum and pancreas) or not decreasing as fast as they are in Whites. Blacks experience mortality rates for esophageal cancer, cancers of the cervix, breast, uterus, multiple myeloma, and prostate cancer (Ries, et. al., 1990).

Blacks also experience poorer five-year relative survival for all sites combined. For the period 1981 to 1986, five-year relative survival rates are 38.2% for Blacks (both genders) and 52.0% for Whites, or about 30% lower for Blacks (Ries et al., 1990). Poorer survival for Blacks is particularly marked for cancers of the rectum, larynx, breast (females), corpus uteri, prostate, and bladder. Improvements in survival that have occurred over the past thirty years have not been shared equally by Blacks. If survival rates are analyzed by proxy measures of socioeconomic status, within various income strata Blacks have poorer survival than Whites. Blacks are also slightly less likely than non-minorities to receive cancer treatments (Ries et al., 1990).

A cursory review of the literature suggests that breast cancer is the most commonly diagnosed cancer and the second leading cause of death for women in the United States (Forte, 1995). Additionally, Ljaduola, T.G., M.D., FRCS, & Smith, E.B., M.D. (1998), noted that life style plays an important role in risk factors of breast cancer among African American women. High body mass index and obesity were found to be associated with increased risk of occurrence of breast cancer among African American women.

Statement of the Problem

The problem under investigation is to determine whether or not there is a positive relationship between Health seeking behaviors, Economic Factors, and Breast Cancer Treatment Among African American Women. Breast cancer death rates are higher for Black women than they are for White women (American Cancer Society, 1975). One important reason for this difference is that more Black women have their disease diagnosed when it has spread to other parts of the body. This reduces options for treatment and chances for cure.

There are several reasons why African American women have late diagnosis of the disease: (1) not having routine mammograms, (2) African American women are not getting regular physicals and breast exams by a doctor or nurse, (3) African American women are not doing monthly breast self-exams, (4) African American women are waiting too long after finding a lump to see a doctor, and lastly they are afraid to talk and learn more about breast cancer. African American women with low income are less likely to participate in a screening program due to deficits in knowledge and awareness.

Purpose of the Study

The purpose of the study is to assess the relationship between Health Seeking Behaviors, Economic Factors, And Breast Cancer Treatment Decision Making Among African American Women. The cost for breast cancer treatment is very expensive. As aspiring social workers it is important that African American women with breast cancer is informed regarding the various treatment options, payment assistance, and education. The new advances in medical technology which will enable them to be adequately served. Many private organizations and hospitals offer services that will extend to qualifying individuals free mammograms, health pre-screening, and early detection programs in their efforts to lower the fatality rate of breast cancer.

Significance of the Study

There is a fundamental lack of knowledge about the types of health education programs, health promotions, and communication channels that are most effective in marketing preventive health practices to African American women. Educating African American women about economic assistance and better care of their health will decrease mortality rates and increase survival rate. There are few treatment facilities for breast cancer in the African American community. By providing proper human service to this population this will increase survival rate among this race of women.

African American women come from varied backgrounds, which affect their health beliefs and practices. Socioeconomic differences tend to have a greater influence on African American women's experiences with the health care system. This makes it

important for social worker's to understand the effect of socioeconomic factors on clients health beliefs and their ability to use health care sources.

CHAPTER TWO

LITERATURE REVIEW

This chapter will review the literature as it is related to 1) Health Seeking Behaviors, 2) Economic factors, 3) Breast Cancer Treatment Decision Making among African American Women.

Historical Overview

A brief overview of selected references on breast cancer among African American women reveals that research in social work has consistently underestimated the importance of health seeking behaviors and health concerns in the lives of African American women.

Health Seeking Behaviors

According to Chatters (1993), health concerns are particularly crucial among African American women. African American women are twice as likely as Whites to suffer from major chronic illnesses. It is important for social workers to understand and explore issues of health seeking behaviors of African American women. Additionally, there is a grave need for social workers to understand the utilization and under-utilization of services by African American women.

The relevance of this for social work practitioners is that African American women with health problems who do not seek formal help go unaided. Recognition of the health seeking behavior has implications for designing and planning programs to enable African American women to realize their full potential for health. Poverty, racism, and lack of access to health care are three factors having a deleterious effect on the African American woman's health seeking behaviors.

A research study by Deirdra A. Forte (1995), found African American women ages 50 and older have been a difficult group to reach through conventional breast cancer intervention programs. Cultural and health beliefs that differ from mainstream society are reported to be factors contributing to the low rates of breast cancer screening among this group. In addition to these attitudinal factors, older African American women are disproportionately represented among uninsured and under-insured Americans. As a result cost becomes a barrier.

There are many other factors that impact the African Americans health seeking behaviors. In a study conducted by G. Anthony Williams, Ph.D., (1997), found that African American women with low income were less likely to participate in a screening program due to deficits in knowledge and awareness of responsible agents. Additional factors included the belief that mammograms are not really necessary, the cost of mammograms , and the physician lack of referral.

In a study by David Ansell, M.D., M.P.H., Steven Whitman, Ph.D., Rebecca Lipton, Ph.D., and Richard Cooper, Ph.D., (1993), they found that some investigators postulate that biological differences between Blacks and Whites account for at least a

portion of the differences in survival. Others believe that social factors, such as access to treatment and socioeconomic status, may influence breast cancer survival among Blacks. For example, it has been reported that Black women are more likely than White women to receive no treatment for breast cancer.

In addition, Arthur Schatzkin, M.D., D.P.H., Julie R. Palmer, M.P.H., Lynn Rosenberg, Sc.D., (1987), found that late age at menarche was associated with reduced risk of breast cancer. Women having 5 or more children had a reduced risk relative to that of women with fewer or no children. Late age at first birth was associated with elevated risk of breast cancer. Among postmenopausal Black women, obesity was associated with an increased risk; among pre-menopausal women, there was no association of breast cancer with body mass index. Women whose menopause occurred at or after age 50 were at increased risk relative to those whose menopause occurred earlier. History of breast disease and history of breast cancer, in mother, sisters, or both were risk factors.

The association between other social factors and health outcomes has been supported in the study of Jill Moormier, M.D., "Breast Cancer in Black Women", (1996). It was found that demographic characteristics that predict low rates of mammography use include increasing age, low income level, low level of education, rural residence, and lack of health insurance. In addition to these documented demographic findings, surveys of the target population for mammography have identified several important barriers to the regular use of mammography. In Black women, the most

commonly cited reasons for not having mammography is a belief that mammography is not needed if no clinical breast problems are present; the failure of a physician to recommend the procedure; the cost of the procedure; and the knowledge deficited about the increasing risk for breast cancer with age.

Victoria Champion, R.N., D.N.S., and Usha Mennon, R.N., M..S.N., (1997), found that clinical breast examination and mammography rates for African American women fall below the guidelines set by the National Cancer Institute (NCI). It was suggested that although breast cancer screening rates have increased for the general population of women, African American women have demonstrated fewer gains. Most recently, the NCI reported lower awareness about mammography among African Americans as compared to Caucasians. Studies have also shown that African American women have less knowledge of breast self-examination than do Caucasian women.

A research study, done by Beth A. Jones, Stanislav V. Kasl, and Mary G. McCrea Curnen, (1997), found that the significance of their findings indicated that the increased prevalence of severe obesity among African American women can explain that almost one third of their excess risk for later stage at diagnosis must be considered in the context of other possibilities. Historically, hypothesized causes for the later stage at diagnosis in Blacks relative to Whites have included racial differences in socioeconomic status, differences in access to health care, and the related issue of screening behavior.

Most African American women have learned that hypertension is a problem, but most African American women are believed to be unaware of the magnitude of the problem of cancer. African Americans experience higher incidence, higher mortality,

and poorer survival from cancer than Whites. Hulka (1982), suggested that cancer of the cervix is more common in African Americans than in White women. Where diagnosed early, this is a highly treatable form of cancer.

Nomura (1981), noted that a significant factor that contributes to the lack of positive health seeking behavior is that persons in the lower socioeconomic positions are less likely to receive preventive services, such as Pap Smears and breast examinations. Progress in the reduction of cancer will require more emphasis on prevention research and on education of the African American community with respect to the early signs and to the necessary changes in health seeking behavior (Davis, 1986).

Economic Factors

The number of African American women with cancer in our society has perhaps become an important economic issue because of their dependence on public assistance. Historically, poor African American women with cancer were of little political and economic importance to the social work profession. Donald R. Lannin, M.D. (1998) suggested that socioeconomic factors in conjunction with cultural beliefs, cost, and attitudes may explain the dramatic effect of race on breast cancer. According to the American Cancer Society (1995), the society provides programs, free of charge, to assist those with breast cancer who do not have access nor economic support for the services that they need.

Lydia Komarnicky, M.D., (1982), mentioned that one can choose from a low or no cost treatment plan. For example, during breast cancer awareness month, some agencies will provide free mammogram testing. There are agencies that provide sliding scale fees for those who are not able to pay full cost of treatment. Laura Randolph (1997), found that African American women are twice as likely as White women to die from the disease of breast cancer because of late detection of the disease due to lack of economic support.

According to the American Cancer Society (1997), the mortality rates of African American women as well as White women have decreased because of frequency mammograms, chemotherapy and radiation therapy and economic support.

Danette G. Kauffman (1989), noted that individuals eligible for Medicare coverage can elect hospice benefits instead of their standard Medicare benefits. In order to select hospice benefits, patients must be certified by their doctor and the hospice medical director as having six months or less to live. The patient must sign a statement electing hospice care benefits, acknowledging that all of their care must be provided by the hospice program.

Results of the study by Shirley Harrison (1987), revealed that if you have already taken out a policy with a private health insurance company and cancer is diagnosed, you are covered for any treatment recommended by your consultant up to the cut-off period of 180 days in the hospital. This includes chemotherapy, surgery, and radiotherapy, as well as homeotherapy, acupuncture and any complementary treatment.

A study by John Link (1998), mentioned that with recent changes in health care delivery, many women have difficulty finding someone who can coordinate their care. In managed care situations, choices may differ from the private-practice model. If you are in the Health Maintenance Organization (HMO), one can receive "STATE OF THE ART" therapy, but it is critical that one become well educated and play a leading role in your care. One may have to go outside of their HMO for a second opinion.

Kathy LaTour (1993), said that before using a prescription to get a prosthesis, check with your insurance company. Some stipulate either a prosthesis or reconstruction later, which is more expensive, one may want to cover the cost of the prosthesis themselves. If an individual is considering a bilateral, take insurance into consideration. Some policies will cover reconstructing both breast if you are high-risk or can convince the company of the need to remove both, but they won't cover alterations of the remaining breast.

Marion Morra and Eve Potts (1990), noted that group insurance is probably the best option available for recovering cancer patients. Because there is no legal requirement that an insurer grant coverage to anyone, and because legally, insurance companies can set premiums at any level, provided they are based on sound actuarial practices, independent insurance coverage can be a problem for people who have cancer.

John Laszlo, M.D., (1987), found that Medicare and other insurance policies have a statement to the effect that they cover a certain percentage of usual and customary charges. Most people do not understand that insurance companies establish these charges

by looking at the financial records of several institutions and determining a usual fee for a particular service; then they will pay only their required percentage of that average on matter what the actual charge.

In a study done by Harold Glucksberg, M.D., (1985), he mentioned that a person can get financial help without health insurance. For example, the Veteran's Administration and Public Health Hospitals, if you have poor health insurance and have cancer, they advise finding out if you qualify for free care at a Veteran's Administrative Hospital or a Public Health Service Hospital. If you have been in any of the armed services, you are eligible to be treated at a Veteran's Hospital. Likewise, if you have been in the Merchant Marines or are a Native Indian, you can be treated free of charge.

According to a study by Maurice E. Schweitzer, Michael T. French, Steven G. Ullmann, and Clyde B. McCoy, (1998), their findings indicate that the actual cost-effectiveness of breast cancer screening, however, is uncertain. Most of these differences were attributed to discrepancies in the underlying assumptions used between analyses. Deriving cost-effectiveness measures for screening minority populations is particularly problematic since few studies have assessed either the cost or benefits of screening African American or Hispanic women.

Results in a study by Victoria Lee Champion, D.N.S., R.N., Usha Menon, M.S.N, R.N., Diane Hollinden McQuillen, B.S., Catherine Scott, B.S.N., R.N., (1998), indicated that for women 50 to 69 years of age, regular mammography screening leads to a 25% to 30% reduction in mortality. Even though breast cancer mortality has started to decline in the past year, the mortality for African American women (31%) still exceeds that of the

Caucasian population (27%). Black women of lower socioeconomic status were close to four times more likely to have late-stage breast cancer than their White counterparts. The five year survival rate for African Americans diagnosed with breast cancer is 70% as compared to 85% for Caucasians. This disparity in the five year relative survival rate may be due in part to the later stage of disease at the time of initial diagnosis related to economic factors.

A research study by Mary Altpeter, Joanne L. Earp, and Janice H. Schopler, (1998), found that there is a need for comprehensive community oriented interventions to increase breast cancer screening rates in African American communities. The North Carolina Breast Cancer Screening Program is one such program. This program is based in five rural, low-income medically undeserved counties in eastern Northern Carolina. These counties encompass 1,200 square miles and are sparsely populated; only two towns have populations that exceed 5,000. African Americans are a larger portion of the total population than in North Carolina as a whole. This program educates clients of low treatment options.

A research study performed by Yashar Hirshaut, M.D., F.A.C.P. & Peter I. Pressman, M.D., F.A.C.S., (1992), found that mammograms cost from fifty to two hundred dollars a year, depending largely on the part of the country. Of the women most vulnerable to breast cancer, those over forty, only sixty-five percent have had any mammograms in their life time and only seventeen percent had one the previous year. Medicare pays fifty-five dollars each, but only for mammography, and when government or private insurers are trying to cut costs, it is mammograms they seem to cut first.

Taiwon G. Ljaduola, M.D., FRCS, and Earl B. Smith, M.D., "Pattern Of Breast Cancer Among White Americans, African American, and non-immigrant West African Women" (1998), have found that there are many conflicting findings about social, educational, and economic factors and breast cancer. Some researchers have reported that African Americans with less than 12 years of education have a higher risk of breast cancer than those with 12 or more years of education.

While researching an article by Ralph J. Coates, Diana D. Bransfield, and Margrett Wesley, " Differences Between Black and White Women With Breast Cancer in Time From Symptom Recognition to Medical Consultation" (1992), the researcher found that in the United States, White women have a lower fatality rate than Black women following a diagnosis of breast cancer. From 1981 through 1986, the 5-year relative survival rate was 64% among Black women and 78% among White women.

Black women are much more likely than White women to be diagnosed with later stage disease, but racial differences in survival remain even after controlling for stage of disease at diagnosis. Some researchers have found that adjustment for socioeconomic status eliminates survival differences. Additional explanations include more limited access to health care by Black women, diagnostic under-staging of tumors by physicians examining Black women, and less appropriate or aggressive therapeutic management for Black women.

Mary-Ellen Siegal (1986), informed us that clinics will usually accept whatever insurance that a person may have, they will guide you toward seeking Medicaid or

Medicare, or accept fees on a sliding scale based on ability to pay. Cancer can sometimes be considered a disability, making one eligible for Medicare.

According to Dr. Phillip Strax (1989), the cost of an examination, including mammography, is of little importance when examining the comparatively few women who truly show a possible problem. When large numbers of a symptomatic and minimally symptomatic women are involved, in mass screening, they are from the low income bracket. The cost of the procedures, particularly that of mammography, becomes important.

Results from the study by Paul M. Levitt, Elissa S. Guralnick with Dr. A. Robert Kagan & Dr. Harvey Gilbert (1980), indicated that all cancer insurance will pay for hospital bills, doctor bills (that is hospital-related), surgery and radiotherapy for the treatment of cancer. Some insurance companies will pay a percentage of all legitimate expenses, less the deductible amount. For example, a person will pay the first $1,000, and the insurance company will pay 50% of the next $1,500 and 80% of the remainder. In most cancer insurance, hospital coverage is inadequate for a person who stays less than ninety days. The average hospital stay for a cancer patient is sixteen days at a total cost of about $400 a day ($6,400).

Decision Making

Janis & Mann (1977), noted that problem-solving and decision theory offers practitioners guidelines for assisting clients to resolve problems using techniques that clients themselves can employ for coping with present or future problematic situation.

The decision making process of African American women with breast cancer appears to be associated with a host of factors: (1) economic factors, (2) access to services, (3) transportation, and (4) poor health seeking behaviors. Myers (1984), notes that the usual explanation offered regarding barriers to health utilization and decision making health care factors is that low social status is a major impediment to good health.

However, James (1984), found that Blacks with hypertension of all social classes report less frequent use of medical care, more difficulties in getting into the health care system, and greater dissatisfaction with medical care services than do similarly afflicted Whites.

Edmonds (1982), noted that for a variety of reasons, African American women, more than White women, tend to put off seeking medical care and are also less likely to have a regular source of medical care. There are proportionately fewer doctors, clinics and other health care providers in African American neighborhoods, and many inner-city hospitals are either closing or moving to the suburbs.

To better understand that factors surrounding the decision making process of African American breast cancer women, Mechanic (1982), is relevant. He identified racial prejudice, lack of education, and health knowledge, suspicion of and alienation from bureaucratic organizations, lack of access to facilities, and unrealistic perceptions of health status are all variables that must be considered when analyzing the decision making process of African American women.

Ruther and Dobson (1981), found that approximately 12% of the total population reported problems in getting access to health care – and the problems were greater among

poor Blacks and other racial minorities. Neighbors and Jackson (1986), noted that there is less insurance coverage among Blacks, less continuity of insurance coverage, and more dissatisfaction with health care.

The use of hospital outpatient departments and emergency rooms has implications for the decision making process among African American women. Diagnosis and treatment, along with quality and continuity of care are enhanced by a provider's knowledge of the patient's history - by patient follow-up, and by a good provider-patient relationship. Difficulties of access and issues of confidentiality, consent and ability to pay pose barriers that make African American women to make positive decisions about health care.

Looking at perceived health status, Pearlin and Schooler (1978), found a tendency for African American women to rate one's health as very good in spite of evidence to the contrary, this may be a coping strategy: "denial, passive acceptance, withdrawal, an element of magical thinking, avoidance of worry and tension is the same as problem solving". Over the course of one's life, few events occur which have the enormous ramifications of breast cancer. In order to provide services to the African American breast cancer woman, social workers need to develop special techniques, based on studies concerned with why African American women generally under-utilize health-care services.

African American women with breast cancer have their own styles of making decisions regarding priorities and need. Access to services, waiting periods, limited sites

of care, and cultural conditioning may contribute to or insulate the decision making process. Cultural beliefs have a profound influence on the health of people. While available data do not provide conclusive evidence regarding African American women's decision making about access to care, it does appear that access to care by minorities and the poor increases with the availability of minority providers.

Theoretical Framework

Much of the work and research that has been conducted on African American women with breast cancer, has utilized a victim-centered approach. According to Wilson Ford (1990), failure to increase our understanding about the overall coping capacity of African American women is a consequence of this victim-centered approach and orientation.

There appears to be a lack of adequately developed theories regarding African American women in the health care / social work profession. This lack of adequately developed theories regarding this population to be compared primarily on the basis of race or cultural background. Consequently, if differences do appear, the analyses tend to attribute these variations to racial and cultural differences when, in fact, they may stem from the effects of such factors as socioeconomic status. These problems lead Jackson (1990), to the conclusion that the "nobody of theory about.... African American women with breast cancer exists."

The applications of empowerment theory to study of African American women with breast cancer emphasize the importance of understanding issues of oppression. Solomon (1976), made explicit, her concerns for the needs of clearly-identifiable groups

in society (particularly ethnic minorities and groups suffering from various forms of social stigma due to disability) who are oppressed. Furlong (1987), views empowerment as an important goal in social work because it avoids crude polarization of social action and individualized perspectives, placing work with individuals and families in a context of concern for social objectives.

Advocacy is another important strand of social work practice which seeks to promote clients' own control and involvement in their lives, communities, and service. Collins (1991), suggests that an Afrocentric feminist analyses of Black women be investigated for the interlocking nature of Black women's oppression. Such analyses stimulate a better appreciation of the powerful and complex interplay between Black women's position and patterns of racial oppression, and gender subordination. An Afrocentric feminist analyses of Black women promises to shed some light on ongoing debates concerning social class.

Surdarkasa (1981), points out that the Afrocentric worldview offers alternative definitions about African American women, family and community. One implication of an Afrocentric feminist epistemology is that it is rooted in the everyday experiences of African American women (Spelman, 1982). The Afrocentric feminists' thought offers two significant contributions among knowledge, consciousness, and empowerment. This reconceptualiztion process fosters a fundamental shift in the perception of the African American women. The existence of Afrocentric feminists' thoughts suggests that there is always a choice and the power to act, no matter how bleak the situation may appear to be.

Powerlessness in individuals or social groups is defined by Solomon (1976), as the "inability to manage emotions, skills, knowledge and/or material resources in a way that effective performance of valued social roles will lead to personal gratification. Empowerment aims to use specific strategies to reduce, eliminate, combat and reverse negative valuations by powerful groups in society affecting certain individuals and social groups. An empowerment strategy requires commitment to both maintenance and improvement of effective equal services and also to confrontation of pervasive negative valuation. Social workers must always be aware of powerlessness.

However, the framework to support this research study will be the Empowerment Theory. Barbara Solomon's issues of Black Empowerment (1976), applies to all oppressed communities, but it has more emphasis on Black ethnic minorities. This theory implies that we all need personal and financial resources to accept valued identities and roles. Empowerment uses specific strategies to reduce, eliminate, combat and reverse negative valuations by powerful groups in society affecting certain individuals and social groups. The purposes of empowerment are to help clients see: (1) themselves as casual agents in finding solutions to their problems, (2) social workers as having knowledge and skills that clients can use, (3) social workers as peers and partners in solving problems and (4) the power structure as complex and partly open to influence.

Definition of Terms

- Breast Cancer: Cancer that starts in the breast (American Cancer Society, 1996).
- Breast Cancer Treatment: Treatment of the breast if one is diagnosed with the disease.
- Bilateral: Affecting both sides of the body; for example bilateral breast cancer is cancer occurring in both breast at the same time or at different time (American Cancer Society, 1996).
- Chemotherapy: Treatment used to destroy cancer cells (American Cancer Society, 1996).
- Decision Making: The degree to which a person commits to implement a decision for a new course of action.
- Medicare: An insurance program administered by the Health Care Financing Administration of the federal government. It is for people over sixty-five years of age and those who have been disabled for two years or more (John Laszlo, M.D., 1987).
- Medicaid: A program that offers assistance to low-income patients. It helps pay for help for a number of different kinds of health care (John Laszlo, M.D., 1987).
- Radiotherapy: Treatment with radiation to destroy cancer cells (American Cancer Society, 1996).

Statement of Hypotheses

There are statistically significant relationships between health seeking behaviors, economic factors, and breast cancer treatment decision making among African American women.

Null Hypotheses

There were no statistically significant relationships between health seeking behaviors and breast cancer treatment decision making among African American women.

CHAPTER THREE

METHODOLOGY

Research Design

This is an exploratory and descriptive study. An exploratory research design is a design which explores a research question about which little is known, in order to uncover generalizations and develop hypotheses that can be investigated and tested later with more precise and, hence more complex designs and data gathering. Descriptive designs are used to provide detailed information about the interrelationship of certain variables in question (Grinnell, 1987).

Setting

The setting for this sample population consisted of African American women in graduate and undergraduate programs at Clark Atlanta University Center. The distribution of the questionnaire took place at the Paschal's Center and the Robert W. Woodroff Library.

Sampling

The non-probability convenience sample was utilized. The sample contained 30 African American women who were most convenient to the researcher. The ages of the participants ranged from 18-41 years old. All of the participants of the questionnaire were African American students of Clark Atlanta University.

Data Collection Procedure (Instrumentation)

The data for this study were obtained through personal, face to face contact with students that attend Clark Atlanta University. The instrument was administered at the Robert W. Woodruff Library and the Paschal's Center at Clark Atlanta University. There were 30 African American women who agreed to participate in the study.

The participants were given a consent form (Appendix A) and a four-page questionnaire (Appendix B). Each participant was instructed to read the consent form before participating in the research. The questionnaire consists of 20 questions. The body of the questionnaire consisted of 3 sections: (1) Demographics, (2) Economic Factors, and (3) Health Seeking Behaviors.

The questionnaire took 5-7 minutes to complete. The participants were given thanks for participating in the research. The questionnaire was collected from the participants after their completion. The reliability and validity of this study can only be generalized from the population studied. The questions contained in the questionnaire were formed by the researcher. The rating scale in Section 3 of the questionnaire were from Kevin Crocoran and Joel Fischer's "Measures for a Clinical Practice: A Source Book", (1987).

Data Analysis

Data collected were coded on the SPSSX batched system of the Vax Computer System. Statistical data analysis employed included descriptive statistics, frequency distributions, percentages, and Chi Square.

CHAPTER FOUR

PRESENTATION OF RESULTS

The data collected in this study provides a profile of 30 African American women who participated in the questionnaire on Health Seeking Behavior, Economic Factors, and Breast Cancer Treatment among African American Women. Information in this chapter has been arranged in three sections: (1) Demographics, (2) Economic Factors, and (3) Health Seeking Behaviors.

Demographics

Table 1
(N=30)

1. Age

	Frequency	Percentage (%)
18-25	20	66.7
26-33	9	30.0
34-41	1	3.3
58-65	0	0
66-73	0	0
Total	30	100

The results in table 1 indicate that 66.7% of the respondents ranged in ages 18-25; 30.0% of the respondents ranged in ages 26-33; 3.3% of the respondents ranged in ages 34-41; no respondents for ages 58-65, 66-73.

Table 2
(N=30)

2. Education

	Frequency	Percentage (%)
High School	7	23.3
Some College/Technical	8	26.7
Bachelor's	5	16.7
Master's	1	3.3
Others	9	30.0
Total	30	100

The results in table 2, indicate that out of 30 participants, 23.3% had a high school education, 26.7% had some college/technical training, 16.7% had a bachelor's degree, 3.3% had master's degrees, and 30.0% had other educational background.

Table 3
(N=30)

3. Religion

	Frequency	Percentage (%)
Christian	10	33.3
Baptist	7	23.3
Methodist	3	10.0
Other	6	20.0
None	4	13.4
Total	30	100

The results in table 3, show that 33.3% of the participants were Christians, 23.3% were Baptist, 10.0% were Methodist, 20.0% responded other, and 13.4% classified themselves as no religion.

Table 4
(N=30)

4. Residency

	Frequency	Percentage (%)
City of Atlanta	18	60.0
DeKalb Co.	3	10.0
Fulton Co.	4	13.3
Clayton Co.	1	3.3
Cobb Co.	3	10.0
Other	1	3.3
Total	30	100

The results in table 4, show that out of 30 participants, 60.0% lives in the Atlanta City Limits; 10.0% live in DeKalb County; 13.3% reside in Fulton County; 3.3% live in Clayton County; 10.0% reside in Cobb County; and 3.3% live in other counties.

Table 5
(N=30)

5. Employment Status

	Frequency	Percentage (%)
Full Time	11	36.7
Part Time	1	3.3
Unemployed	18	60.0
Total	30	100

The results in table 5, indicate that 36.7% of the participants were employed full-time; 3.3% were employed part-time ; and 60.0% were unemployed.

Table 6
(N=30)

6. Profession

	Frequency	Percentage (%)
Student	17	56.7
Social Work	3	10.0
Psychology	1	3.3
Education	1	3.3
Consultant	2	6.7
Music	1	3.3
None	5	16.7
Total	30	100

The results in table 6 show that out of 30 participants 56.7% responded that their profession was student; 10.0% social workers; 3.3% answered psychology; 3.3% answered education; 6.7% of the participants were consultants; 3.3% were musicians; 16.7% had no profession.

Table 7
(N=30)

7. Annual Income

	Frequency	Percentage (%)
0	14	46.7
1-10,000	9	30.0
10,001-20,000	4	13.3
20,001-30,000	2	6.7
30,001 or more	1	3.3
Total	30	100

The results in table 7 show the income ranges from $1,000.00 - $30,001.00 or more. There were 46.7% of the participants who had no income; 30.0% who had the income between $1 - $10,000. There were 13.3% of the participants who had income between $10,000 - $20,000. There were 6.7% of the participants who had income between $20,001 - $30,000. There were 3.3% of the participants who had the income of $30,001 or more.

Economic Factors

Table 8
(N=30)

8. Do you have Medical Insurance?

	Frequency	Percentage (%)
Yes	23	76.7
No	7	23.3
Total	30	100

Out of 30 participants, 76.7% had medical insurance and 23.3% had no medical insurance.

Table 9
(N=30)

9. Do you have health insurance?

	Frequency	Percentage (%)
Yes	24	80.0
No	6	20.0
Total	30	100

The table shows that out of 30 participants, 80.0% of the respondents had health insurance and 20.0% of them had no health insurance.

Table 10
(N=30)

10. Do you have Medicaid?

	Frequency	Percentage (%)
Yes	1	3.3
No	29	96.7
Total	30	100

The table shows that 96.7% of the participants had no Medicaid and 3.3% had Medicaid.

Table 11
(N=30)

12. Do you have Medicare?

	Frequency	Percentage (%)
Yes	1	3.3
No	29	96.7
Total	30	100

The results in table 11 indicate that 96.7% of the participants have Medicare, and 3.3% of them do not.

Null Hypothesis

(H1): The Null Hypotheses was rejected. There were no statistically significant relationships between health seeking behaviors and breast cancer treatment decision making among African American women.

Health Seeking Behaviors and Breast Cancer Treatment

Table 12
(N=30)

13. Have you ever inquired about complimentary mammograms?

	Frequency	Percentage (%)
Yes	30	100
No	0	0
Total	30	100

According to the results in table 12, out of 30 participants 100% of the participants answered yes.

Table 13
(N=30)

14. If you were a victim of this disease would you inquire about financial support programs for treatment?

	Frequency	Percentage (%)
Yes	30	100
No	0	0
Total	30	100

The results in table 13 show that out of 30 participants 100% answered yes.

Table 14
(N=30)

15. If you had breast cancer would you inquire about sliding scale fee to decrease the cost of treatment?

	Frequency	Percentage (%)
Yes	30	100
No	0	0
Total	30	100

The results in table 14 indicate that all of the participants answered yes.

Table 15
(N=30)

16. Do you worry about your health?

	Frequency	Percentage (%)
No	0	0
Rarely	0	0
Sometimes	7	23.3
Often	8	26.7
Most of the time	15	50.0
Total	30	100

The results in table 15 indicate that 23.3% of the participants answered sometimes; 26.7% answered often; 50.0% of the participants answered most of the time.

Table 16
(N=30)

17. Does the thought of a serious illness scare you?

	Frequency	Percentage (%)
No	0	0
Rarely	1	3.3
Sometimes	8	26.7
Often	16	53.3
Most of the time	5	16.7
Total	30	100

Table 16 indicates that 3.3% of the participants answered rarely; 26.7% answered sometimes; 53.3% answered often; 16.7% of the participants answered most of the time; and 0% said no.

Table 17
(N=30)

18. Do you avoid habits that may be harmful to you such as smoking?

	Frequency	Percentage (%)
No	0	0
Rarely	3	10.0
Sometimes	3	10.0
Often	17	56.7
Most of the time	7	23.3
Total	30	100

The results in table 17 indicate that 10.0% of the participants answered rarely; 10.0% answered sometimes; 56.7% answered often; 23.3% answered most of the time; and 0% said no.

Table 18
(N=30)

19. Do you avoid food, which may not be helpful for you?

	Frequency	Percentage (%)
No	0	0
Rarely	3	10.0
Sometimes	6	20.0
Often	17	56.7
Most of the time	4	13.3
Total	30	100

The results in table 18 indicate that 10.0% answered rarely; 20.0% answered sometimes; 56.7% answered often; 13.3% answered most of the time; and 0% said no.

Table 19
(N=30)

20. Do you exercise?

	Frequency	Percentage (%)
No	0	0
Rarely	2	6.7
Sometimes	14	46.7
Often	13	43.3
Most of the time	1	3.3
Total	30	100

The results in table 19 show that 6.7% answered rarely; 46.7% answered sometimes; 43.3% answered often; 3.3% answered most of the time; and 0% said no.

Table 20
(N=30)

21. If you were diagnosed with breast cancer would you get a second opinion regarding treatment?

	Frequency	Percentage (%)
Yes	29	96.7
No	1	3.3
Total	30	100

The results in table 20 indicate that 96.7% answered yes and 3.3% answered no.

Null Hypothesis

(H2): There were no statistically significant relationships between health seeking behaviors and economic factors.

Health Seeking Behaviors and Insurance

Table 21
(N=30)

22. Do you worry about your health?

	No	Rarely	Sometimes	Often	Most of the time	Total
With insurance	0	0	7	7	11	25
Without insurance	0	0	0	1	4	5
Totals	0	0	7	8	15	30

$X^2 = 2.58$, $df = 2$, $p < .05$

There were no statistically significant relationships between health seeking behaviors and insurance. The hypothesis was rejected. Chi square results were 2.58, degree of freedom=2, and the probability was less than .05.

Table 22
(N=30)

23. Does the thought of a serious illness scare you?

	No	Rarely	Sometimes	Often	Most of the time	Total
With insurance	0	1	8	12	4	25
Without insurance	0	0	0	4	1	5
Totals	0	1	8	16	5	30

X 2=2.58, df=2,p<.05

The results show that there were no statistically significant relationships between health seeking behaviors and insurance. The Chi Square result are 2.58, degree of freedom=0.2, and the probability was less than .05.

Table 23
(N=30)

24. Do you avoid habits that may be harmful to you such as smoking?

	No	Rarely	Sometimes	Often	Most of the time	Total
With insurance	0	3	2	15	5	25
without insurance	0	0	1	2	2	5
Totals	0	3	3	17	7	30

$X^2 = 2.21$, df = 3, $p < .05$

Table 23 indicates that there were no statistically significant relationships between health seeking behaviors and insurance. The Chi Square results were 2.21, degree of freedom=3, and the probability was less than .05.

Table 24
(N=30)

25. Do you avoid foods, which may not be helpful for you?

	No	Rarely	Sometimes	Often	Most of the time	Total
With insurance	0	3	5	15	2	25
without insurance	0	0	1	2	2	5
Totals	0	3	6	17	4	30

$X^2 = 4.09$, df = 3, $p < .05$

The results in table 24 indicate that there were no statistically significant relationships between health seeking behaviors and insurance. The Chi Square results were 4.09, degree of freedom=3, and the probability was less than .05.

Table 25
(N=30)

26. Do you exercise?

	No	Rarely	Sometimes	Often	Most of the time	Total
With insurance	0	2	13	9	1	25
without insurance	0	0	1	4	0	5
Totals	0	2	14	13	1	30

$X^2 = 3.38$, df = 3, $p < .05$

In table 25 the researcher found that there were no statistically significant relationships between health seeking behaviors and insurance. The Chi Square results were 3.38, degree of freedom=3, and the probability was less than .05.

Employment Status and Health Seeking Behaviors

Table 26
(N=30)

27. Do you worry about your health?

	No	Rarely	Sometimes	Often	Most of the time	Total
Employed	0	0	3	3	6	12
Unemployed	0	0	4	5	9	18
Totals	0	0	7	8	15	30

$X^2 = 0.045$, df = 2, $p < .05$

Table 26 indicates that there were no statistically significant relationships between employment status and health seeking behaviors. The Chi Square results were 0.045, degree of freedom=2, and the probability was less than .05.

Table 27
(N=30)

28. Does the though of a serious illness scare you?

	No	Rarely	Sometimes	Often	Most of the time	Total
Employed	0	0	2	6	4	12
Unemployed	0	1	6	10	1	18
Totals	0	1	8	16	5	30

$X^2 = 4.79$, df = 3, $p < .05$

In response to question 28, the results in table 27 indicate that there were no statistically significant relationships between health seeking behaviors and employment status. The Chi Square results were 4.79, degree of freedom=3, and the probability was less than .05.

Table 28
(N=30)

29. Do you avoid habits that may be harmful to you such as smoking?

	No	Rarely	Sometimes	Often	Most of the time	Total
Employed	0	0	2	7	3	12
Unemployed	0	3	1	10	4	18
Totals	0	3	3	17	7	30

$X^2 = 2.92$, df = 3, $p < .05$

The results in table 28 indicate that there were no statistically significant relationships between health seeking behaviors and employment status. The Chi Square results were 2.92, degree of freedom=3, and the probability was less than .05.

Table 29
(N=30)

30. Do you avoid foods, which may not be helpful for you?

	No	Rarely	Sometimes	Often	Most of the time	Total
Employed	0	0	3	8	1	12
Unemployed	0	3	3	9	3	18
Totals	0	3	6	17	4	30

$X^2 = 2.98$, df = 3, $p < .05$

The results in table 29 indicate that there were no statistically significant relationships between health seeking behaviors and employment status. The Chi Square results were 2.98, degree of freedom=3, and the probability was less than .05.

Table 30
(N=30)

31. Do you exercise?

	No	Rarely	Sometimes	Often	Most of the time	Total
Employed	0	1	5	5	1	12
Unemployed	0	1	9	8	1	18
Totals	0	2	14	13	2	30

$X^2 = 1.70$, df = 3, $p < .05$

The results in table 30 indicate that there were no statistically significant relationships between health seeking behaviors and employment status. The Chi Square results were 1.70, degree of freedom=3, and the probability was less than .05.

CHAPTER FIVE

SUMMARY AND CONCLUSION

Study findings have important practical implications. Taken together with previously reported evidence from other research, study results lend further support for the argument that race, poverty, racism, economics and culture should not be the single or even primary determinant in planning the overall case management of African American women. The study identified a number of important factors that social workers need to address. Cancer remains the second-leading killer in this country and the death rate from cancer continues to rise. Chi Square Test were used to compare health seeking behaviors and insurance. Table 21, question 22, *Do you worry about your health with or without insurance?* The hypothesis was rejected. Chi Square results were 2.58, degree of freedom = 2, and the probability was less than .05. The Chi-Square comparison found no significant relationship on the study variables.

Consistent with results from a study Williams (1997), African American women with low-income were less likely to participate in a screening program due to deficits in knowledge and awareness of responsible agents. Table 12, question 13, *Have you ever inquired about complimentary mammograms?* In this regard, out of 30 participants, 100% said yes. It appears that this population of African American women are able to use supportive health services.

In any case, study results suggest that practitioners should routinely assess the need for services among the African American women and when necessary assist in mitigating barriers to their use.

Results from a study by Moormier (1996), found that demographic characteristics that predict low rates of mammography use include age, low-income level, low level of education, and lack of insurance. Results from this study, Table 1, question 1, Age, indicated that 66.7% of the respondents ranged in ages 18-25; Table 2, question 2, Education, indicated that 23.3% of respondents had high school education; 26.7% some college / technical education; 16.7% had a Bachelors; 3.3% had a Masters; 30.0% indicated other. This suggests that African American women that have high levels of education and age, despite other limitations, African American women in the current study raise practical concerns. Again, social work practitioners are advised to consider the needs of this population in designing and implementing their interventions.

Chatter (1993), suggested that African American women are twice as likely as Whites to suffer from major chronic illnesses. With respect to assessment, there is evidence that several well validated self-report instruments can be used with this population. Our findings are that African American women 18-25 may not encounter barriers to participation such as a lack of insurance and transportation.

Study findings also have theoretical implications. The theoretical importance of empowerment theory, Solomon (1976), made explicit her concerns for the needs ofclearly identifiable groups in society (particularly ethnic minorities and group suffering

from various forms of social stigma due to disability) who are oppressed. Collins (1991), proposed an Afrocentric feminist analyses of Black women to investigate the interlocking nature of Black women's oppression. The theoretical importance of empowerment and Afrocentric feminist dimensions should be recognized as an important social work tool. The existence of Afrocentric feminist thought suggests that there is always choice, and power to act, no matter how bleak the situation may appear to be.

Other study findings have identified the developmental perspective, contextual perspectives, and ecological perspectives. In the face of racism, poverty, and other environmental problems, the empowerment theory and Afrocentric feminist analyses may directly contribute to a better understanding of the African American women. Lannia (1998), suggested that economic factors alone were not sufficient to explain the dramatic effect of racism, race on breast cancer; however, socio-economic variables in conjunction with cultural beliefs, cost, and attributes could largely account for the observed results of this study.

The hypothesis for this study was rejected. Chi-Square results were 2.58; degree of freedom = 2, and the probability was less than .05. Some of the findings in this study were consistent with previous studies found in Chapter Two, Literature Review. The present findings revealed that there is cause for concern for social work practitioners with this populations unmet need for help among African American women. Some of the findings replicate the results of research by others on economic factors and breast cancer treatment decision making.

Limitations of the Study

It is important to recognize several limitations of this study: (1) participants were all African American women; (2) low statistical power due to the small sample size; (3) African American women and other ethnic groups with cancer was not considered, and (4) lack of cultural diversity.

It is plausible, therefore, that the study results best described the population of African American women who participated in the study. While this study is limited by the small sample size and lack of cultural diversity, it is hoped that these results may improve the understanding of social work practitioners in the delivery of effective social services.

Suggested Research

Breast cancer is an illness that requires close attention. Further research is needed for continuation and maintenance treatment so as to prolong the period of recovery. There is a need to rigorously design studies of social work inter-vention outcomes with these populations. There is a need for more research on illness-related factors, coping resources, and psychological adaptation of African American women with/without breast cancer.

Future research on a larger sample is needed to provide the opportunity to examine more closely different age groups. More information about potential barriers to the use of Empowerment Theory and Afrocentric Feminist Prospective among African American women is also needed.

There is a need for in-service training and public awareness to be focused on social workers and other health care professionals.

CHAPTER SIX

IMPLICATIONS FOR SOCIAL WORK PRACTICE

Overall, this study reveals the need for empirical social work research on this population. As a profession, we rely too heavily on findings from other professions.

There is a need to contribute to social work knowledge about African American women in general. Social workers need to understand that the single-mother African American is not a result of slavery, or of welfare policies, nor is it a traditional family form, rather, it is the result of poverty, racism, African American male underemployment / unemployment.

Many of the problems that beset the African American woman's health seeking behaviors and decision making are due to racial discrimination and the difficult economic conditions under which a disproportionate number of African American women live. Social workers need to understand that poor African American women adapt to poverty through a variety of arrangements.

African American women are the most likely candidates for breast cancer and cervical cancers. Social workers need information on contraceptives. All that can possibly be said now is that no certain cause-and-effect relationships have been established between the pill and breast cancer (Remez, 1991). Nevertheless, social workers need to appreciate that all women, users of the pill or not, must be urged to get annual breast examinations.

There are several significant theoretical perspectives that may have implications for social work practice. An understanding of Empowerment Theory, Solomon, (1972), and an Afrocentric Feminist view, Collins, (1991), are important tools for social workers with the African American woman.

African American women have a number of positive characteristics that have enabled them to function and survive (Hill, 1997). These characteristics are: (1) strong kinship bond, (2) favorable attitude toward the elderly, (3) flexible roles, (4) strong religious orientation, (5) love of children, (6) strong achievement orientation. There is a need to enhance social workers understanding of the strength perspective. Perhaps this will help social workers to understand the issues around African American women health seeking behaviors and decision making process around breast cancer. Some social workers may-be unaware of the layers of strengths and, consequently, fail to take advantage of this perspective.

There is a need for social workers to have increased knowledge regarding available services associated with greater use of services by African American women. It is possible that some African American women are not familiar with available services and programs. Another practice issue is that the social worker may provide the African American woman with breast cancer information, but the woman chooses not to make use of the information given. This has implications for social work practice / research. It is possible that further research on the belief system of this population is needed.

Certainly, familiar intervention is also a logical area of concern for the African American woman in seeking treatment for breast cancer.

Social workers need to examine the role of religion / spirituality to determine frequency of contact with church related friends as critical factors in accounting for aspects of Health Seeking Behaviors and Decision Making Among African American Women. Social workers may find that, perhaps, it is access to information, which leads to the increase in health seeking behaviors.

It currently appears difficult to identify specific intervention strategies aimed at increasing African American women health seeking behaviors and treatment decisions making regarding breast cancer. However, social workers should focus on (1) Theoretical Perspectives, (Empowerment and Afrocentric Feminist), (2) Strengths Perspective, (3) and Prevention of breast cancer. It seems important for social workers to play a crucial role with African American women in the health care system, especially in the health seeking behavior issue, early detection of breast cancer, and treatment decision making process.

The study did not support the hypothesis. The lack of support for the population may be due to the fact that this study was designed to elicit feelings about health seeking behaviors, economics, and decision making among African American women regarding breast cancer. Further research is needed to clarify these issues. It would be useful to replicate the present study with a much more culturally diverse population. This would give greater generalization to the findings. This would have important implications for social work practice.

Appendices

Appendix A

CONSENT FORM

To Whom It May Concern:

The purpose of this study is to collect data to determine the relationship between Health Seeking Behaviors, Economic Factors and Breast Cancer Treatment Decision Making Among African American Women. This is to assure all participants that they will in no way be harmed during this study. A participant is free to withdraw from this study, for any reason at any point. During the study, someone will be available to answer questions or concerns.

Please sign and date the form indicating that you: (1) understand the information outlined above, and (2) agree to freely participate in the study. Your comment will remain strictly confidential. Thank You for your participation in this study.

Jacquelyn D Jenkins Research Intern 3-25-1999 Date

Jacquelyn D. Jenkins

_____ Respondent _____ Date

Appendix B

SECTION 1

DEMOGRAPHICS

Directions: Please answer the following questions by checking the appropriate response.

1. What is your age range?

   18-25_____ 26-33_____34-41_____ 58-65_____ 66-73_____

2. What is your highest level of education?

   High School _____ Bachelors_____ Other/Specify_____

   Some College/Technical _____ Masters _____

3. What is your religion?_____

4. Where do you reside?

   Atlanta City Limits_____ DeKalb County_____

   Fulton County_____ Clayton County _____ Cobb County _____

   Other/Specify _____

5. What is your current employment status? _____

6. What is you profession? _____

7. What is your approximate income? _____

SECTION 2

ECONOMIC FACTORS

Directions: Please answer the questions by checking the appropriate response.

1. Do you have Medical insurance? Yes ____ or No _____
2. Do you have health insurance? Yes _____ or No _____
3. Do you have Medicaid? Yes _____ or No _____
4. Do you have Medicare? Yes _____ or No_____
5. Have you ever inquired about complimentary mammograms? Yes____ or No ____
6. If you were a victim of this disease would you inquire about financial support programs for treatment? Yes ____ or No ____
7. If you had breast cancer would you inquire about sliding scale fee to decrease the cost of treatment? Yes _____ or No _____

SECTION 3

HEALTH SEEKING BEHAVIOR

Directions: Please answer the following questions by checking the appropriate response.

1. Do you worry about your health?

   No___ Rarely ___ Sometimes ___ Often ___ Most of the time ___

2. Does the thought of a serious illness scare you?

   No ___ Rarely ____ Sometimes ____ Often ___ Most of the time ___

3. Do you avoid habits that may be harmful to you such as smoking?

   No ___ Rarely ____ Sometimes ____ Often ___ Most of the time ___

4. Do you avoid foods, which may be harmful to you?

   No ___ Rarely ____ Sometimes ____ Often ___ Most of the time ___

5. Do you exercise?

   No ___ Rarely ____ Sometimes ____ Often ___ Most of the time ___

6. If you were diagnosed with breast cancer would you get a second opinion regarding treatment? Yes ___ or No ___

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